



UnityPoint at Home

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September 9, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1711-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1711-P – CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements; published at Vol. 84, No. 138 Federal Register 34598-34715 on July 18, 2019.

Submitted electronically via <http://www.regulations.gov>

Dear Administrator Verma,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2020. UnityPoint at Home is the Home Health Agency affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, pharmacy, palliative care, hospice care, and (in certain locales) public health. In 2018, UnityPoint at Home provided more than 610,000 visits to consumers in Iowa, Illinois and Wisconsin. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, and is a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. We respectfully offer the following comments to the proposed regulatory framework.

I. PAYMENT UNDER THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

Proposed CY2020 HH PPS Payment Adjustment: *Medicare payments to Home Health Agencies (HHAs) in CY2020 are proposed to be increased by 1.5% or an estimated \$250 million. CMS is seeking comments on the wage index used to adjust home health payments and suggestions for possible updates and improvements to the geographic adjustment of home health payments.*

Comment: **We appreciate the proposed rate increase.** Over time, payment adjustments have not kept pace with increased costs attributable to labor, technology and mileage. This increase will assist in maintaining healthcare access for Medicare beneficiaries that live in areas of the country where most HHAs are already experiencing very small operating margins.

In terms of developing a wage index to be applied to home health payments, **we do not support CMS's continuing practice of defaulting to the inpatient hospital wage data.** Hospital data is not the best data for this purpose. UnityPoint at Home routinely pays our home health nurses higher wages than their hospital counterparts. This wage differential takes into account a greater level of autonomy and case management engaged in by home health nurses as well as environmental factors, including safety risks due to automobile accidents and workplace violence associated with working in patients' homes. **We would suggest that CMS use home health specific data contained in our cost reports,** which contain average cost per visit. We are also concerned that the geographic adjustments to the wage index disregard specific work effort, as the census for our rural and urban HHA service areas are similar while the geographic area for rural HHAs keeps increasing.

Rural Health Add-On Payments for CYs 2020 through 2022: *The Bipartisan Budget Act of 2018 imposed a -0.2 percent decrease in payments, totaling an estimated -\$40 million.*

Comment: We are extremely frustrated by the continued reduction in support for access to services for rural beneficiaries. In Iowa and central Illinois, we have a significant rural population. Collectively, our HHAs serve 39¹ counties (reduced from 47 counties in 2018), which are classified in the "all other" category. **UnityPoint at Home has had to make tough decisions to close two rural offices in the past year, in addition to eliminating 10 rural counties in our service areas.** This reduction has negatively impacted access to care in low population density areas, where beneficiaries are older, have more chronic conditions, and face provider shortages. To compound matters, areas that receive rural add-on payments typically have much lower wage indices, and therefore are already faced with providing the same level of care as other HHAs but with less Medicare reimbursement. To put this in perspective, the 3 percent add-on is the approximate equivalent of a full-time nurse's (RN) salary. For one of our rural HHAs serving an average of 235 patients per day, the loss of this rural add-on equates to about \$75,000 annually (i.e. the equivalent to one RN FTE).

Payments for High-Cost Outliers: *For CY2020, the Fixed Dollar Loss (FDL) ratio for 60-day episodes is proposed to be 0.51 and for 30-day episodes is proposed to be 0.63.*

Comment: **We support this methodology** and agree that its "per unit" basis is appropriate to account for utilization and accompanying resource allocation by HHAs.

Split-Percentage Payment Approach for CY2020 and Subsequent Years: *CMS is proposing to eliminate the need to submit a Request for Anticipated Payment (RAP) for every period/episode. CMS is proposing to reduce the RAP split-percentage payment to 20 percent for existing HHAs beginning in CY2020 with elimination of split-percentage payments for all HHAs in CY2021. A one-time Notice of*

¹ When compared to 2018, the count of "All Other" counties has reduced by 8 counties, which represents 2 additional counties in Illinois but 10 fewer counties in Iowa.

Admission (NOA) would be filed by all HHAs beginning in CY 2021 to alert the claims processing system that a beneficiary is under a home health episode of care.

Comment: While UnityPoint at Home agrees that the reduction in the RAP split-percentage payment will not significantly impact our cash flow, we have several concerns with the proposed NOA requirement. This is a major change that not only substantially reduces assessment timeframes but also entails infrastructure costs, including EHR builds, HHA workflow changes and staffing reallocations and/or additions. The NOA requirements appear very similar to the Hospice Notice of Election, which itself is operationally cumbersome. As proposed, the one-time NOA requires a comprehensive assessment to be completed within 6 calendar days, including the admission day. This timeframe is challenging, and it has not been piloted anywhere to demonstrate its effectiveness or underlying work effort. To implement, UnityPoint at Home will need to resource staff differently to assure timely submissions, including costly weekend coverage. As an aside, we are concerned that this short turn-around and quicker document production will potentially result in more documentation errors resulting from data entry missteps. In the hospice setting, many hospices failed to meet the Notice of Election (NOE) timely filing requirement because they submitted NOEs with systems-detectable billing errors. To correct these errors, hospices were required to wait for the NOE to be returned to provider (RTP), after which a new NOE could be submitted. In many instances, the systems time required to process the RTP resulted in a failure to submit and accept a replacement NOE timely. Subsequently, CMS changed procedures to allow hospices to immediately submit corrected NOEs without waiting for the RTP process and likewise to immediately resubmit a corrected Notice of Termination/Revocation. Similar flexibility do not seem to be contemplated within the proposed NOA provisions. Beyond staffing, we will also need to realign communications / notifications between our back office and operations teams to sync timeframes for the proposed NOA and updates to the common working file. Additionally, the NOA will require software changes to our EHR. Typically our software vendor requires about a month after release of the Final Rule to push out tested code, which subsequently requires additional internal HHA testing and training. **We urge CMS to reconsider the proposed NOA requirement.**

Patient-Driven Groupings Model (PDGM) and 30-Day Unit of Payment: *The Bipartisan Budget Act of 2018 required a change in the unit of payment from 60-day episodes of care to 30-day periods of care to be implemented in a budget neutral manner. For case-mix weights for 60-day episodes of care spanning implementation of the PDGM, payments will not use the recalibrated methodology; rather these episodes would be paid the national, standardized 60-day episode payment amount and will be case-mix adjusted using the CY 2019 case-mix weights.*

Comment: For the 30-day unit of payment, we agree with the identified case-mix elements and want to reiterate our support for transitioning from a therapy-utilization-driven payment model. We agree that payment based on service volume, rather than patient characteristics and needs, is flawed and does not drive high-quality care.

Behavior Assumptions: We do not support CMS's broad-sweeping application of behavior assumptions totaling an overall payment decrease of 8.01 percent. The magnitude of this decrease, in reaction to bad actors, penalizes an entire industry providing needed services and will force small HHAs and nonprofit HHAs to revisit service areas and services provided. **We urge CMS**

to employ a targeted approach for behavior assumptions based on data, namely the PEPPER reports, evaluated over the course of an entire year and tied to outcomes. For instance, high therapy utilization episodes (20+ therapy episodes) are tracked with the national average roughly at 4% and HHA outliers hitting approximately 30%. CMS should use the PEPPER reports and other collected data to inform revisions to such significant reimbursement framework.

Institutional Admission and Reliance on Inpatient Revenue Cycle: CMS defines an institutional stay, which triggers a heightened PDGM payment, as an acute care hospital stay during a previous 30-day period of care and within 14 days prior to the subsequent, contiguous 30-day period of care. The Medicare claims processing system is used determine the inpatient admission. In terms of mechanics, **CMS has made the 30-day unit of payment dependent upon the inpatient revenue cycle, which results in unintended consequences for HHAs.** If an inpatient provider does not submit their claim timely and HHAs have not manually indicated on Medicare home health claims that an institutional admission source has occurred prior to the processing of an acute/post-acute Medicare claim, HHAs have to engage in a recoupment process to be reimbursement for episodes for which HHAs appropriately provided post-acute care. In addition, if an inpatient provider chooses to take a write-off on the service, HHAs are likewise penalized. **We would request that CMS reconsider the existence of an OASIS assessment to evaluate the admission source information.** This will facilitate timely payment to HHAs for services appropriately rendered without significantly impacting HHA cash flows or adding administrative requirements. Also we would request that CMS specify any appeals process for HHAs and any required documentation for such appeals.

In addition, we believe that reimbursement dependent upon an inpatient claim will promote HHAs to discharge the patient due to hospitalization rather than to transfer patients. As a consequence, **we believe that this payment bump will adversely impact the Discharge to Community measure, which may be counter to CMS intentions.** We would suggest that CMS monitor the rate of discharges due to hospitalizations to determine impact. Alternatively, CMS could consider allowing all post-acute care stays (SNF, IRF, LTCH, or IPF stays) to qualify as an institutional stay to be eligible for the increased payment.

Population Health Goals: We fully support institutional referrals being reimbursed higher than community referrals and appreciate that this is one of the elements that better reflects the complexity and cost of taking care of highly acute hospital discharges. **We urge CMS to monitor of how community referrals are used and their outcomes to determine future revisions to the case-mix valuation.** The long-term goal of all health systems and providers, as encouraged by CMS, is enhanced population health – to lower total overall beneficiary spending while maintaining access and improving quality. One important strategy to achieve this goal is to work with primary care providers on upstream interventions to avoid preventable inpatient admissions. As a result, when a patient is seen in the provider’s office and needs more intervention for an acute exacerbation of a chronic illness or other condition manageable at home, evidence-based protocols are in place for providers to arrange for a same-day admission with nursing intervention to HHAs instead of sending the patient to the hospital.

Also, OASIS-based outcomes measures may not reflect best practices. **We believe the Discharge to Community measure may incentivize inappropriate discharges.** This measure fails to recognize that keeping a patient in the community is not always the best outcome for that patient.

Furthermore, this measure undermines the provision of appropriate care – if an HHA believes a patient will not remain in the community at discharge despite the need for services, this measure would support HHA decisions to not serve the patient entirely or to discharge the patient at time of transfer to an inpatient facility rather than accepting the resumption of care orders. For instance, this measure may encourage some HHAs to cherry pick orthopedic surgical patients and discourage some HHAs from serving rural complex patients.

Institutional Face-to-Face Encounters: Aligned with PDGM purposes, **we would request that CMS eliminate the requirement for the Home Health face-to-face encounters for certification/recertification upon post-acute or skilled discharges.** In situations in which a home health referral is made as part of a post-acute or skilled nursing facility discharge, a mandatory face-to-face encounter for purposes of certification is not necessary and a poor use of physician time and associated costs. We would recommend that CMS permit these certifications to be claims based and to rely upon the medical record of the patient to determine need. In our view, this recommendation is an extension of PDGM framework, in which CMS will be verifying that the home health episode is post-institutional versus community-based, and correlates nicely to the PDGM referral source provisions.

Maintenance Therapy To Be Performed by Therapist Assistants: *CMS is proposing to allow therapist assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the home health benefit. CMS is seeking comment on the frequency of patient reassessment or maintenance program review, appropriate coding, importance of tracking therapy by service or provider, and possible effects on the quality of care.*

Comment: With the removal of therapy thresholds, **we support this change** and believe that it will increase access to maintenance therapy. **We would suggest that CMS revisit Medicare Benefit Policy Manual, Chapter 7 – Home Health Services to provide more guidance on maintenance therapy guidelines to assist HHAs and Medicare Administrative Contractors (MACs) in providing and authorizing these services.** Currently, this topic is addressed in one paragraph in the Manual, and we would seek further clarity on qualifications and documentation requirements for maintenance therapy. In our experience, we believe that this service is underutilized because HHAs cannot document maintenance (e.g. absence of a decline in function) is sufficient for coverage.

Home Health Plan of Care Revisions: *For HHA services to be covered, CMS is proposing that the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. It is CMS' intent that violations for missing required items would be best addressed through the survey process, rather than through claims denials for otherwise eligible periods of care.*

Comment: **We agree with the proposed change.**

II. HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

Iowa is one of the nine states participating in the Home Health Value-Based Purchasing Model pilot, a five-year demonstration project. UnityPoint at Home has 13 locations within Iowa.

- **Quality Measures:** *For CY 2020, CMS is proposing to remove Improvement in Pain Interfering with Activity measure (NQF #0177).*

Comment: **We support removal of this measure.**

- **Public Reporting of Total Performance Scores and Percentile Rankings:** *CMS is proposing to publicly report the Total Performance Score and Total Performance Score Percentile Ranking from the final CY 2020 PY 5 Annual Report for each HHA in the nine Model states that qualified for a payment adjustment for CY 2020.*

Comment: **We support public reporting of the Annual Total Performance Scores and the Total Performance Score Percentile Ranking.** The inclusion of the percentile ranking is an appreciated enhancement and will inform both HHAs and the public, and UnityPoint at Home has advocated for this change in prior comment letters.

III. HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

CY2022 Proposed Measures: *CMS is proposing to remove the Improvement in Pain Activity Measure (NQF #0177) to mitigate any potential unintended, over-prescription of opioid medications. CMS is proposing to adopt two new measures under the Transfer of Health Information category - (1) Transfer of Health Information to Provider–Post-Acute Care; and (2) Transfer of Health Information to Patient–Post-Acute Care. CMS is also proposing to update the specifications for the Discharge to Community–Post Acute Care (PAC) HH QRP measure to exclude baseline nursing facility (NF) residents from the measure.*

Comment: **While we support the removal of the Improvement in Pain Activity Measure, the proposed measures for the Transfer of Health Information category are overly burdensome, duplicative of other initiatives, and contrary to CMS’s Meaningful Measures work.** UnityPoint at Home participated with Change Healthcare and Abt Associates in a pilot for information gathering related to these measures. We found these measures to be labor intensive. Without having the referring provider also participating in this pilot, our HHA intake coordinators were spending up to an additional 30 minutes per patient to speak with referring providers to gather the missing information. Additionally, at the time of the demonstration, our EHR did not support each of the required elements, which added up to 20 minutes of clinical documentation time to ensure all elements were met prior to transfer of information to the provider and/or patient and family. Rather than put this burden on HHAs, we request CMS wait until all providers have the same discharge planning/summary requirements – at that time, all of the requirements of the Transfer of Health Information measures will be met by all care settings, reducing the burden of information finding at home health intake and creating efficiency in information sharing when standardized across all settings.

Standardized Patient Assessment Data Reporting: *For CY2022, CMS is proposing the HHAs would be required to report this data with respect to admissions and discharges that occur between January 1, 2021 and June 30, 2021. Beginning with CY2023, CMS is proposing that HHAs must report data with respect to admissions and discharges that occur the successive calendar year. Reporting categories are (1) Cognitive Function and Mental Status Data; (2) Special Services, Treatments, and Interventions Data; (3) Medical Condition and Comorbidity Data; (4) Impairment Data; and (5) Social Determinants of Health.*

Comment: **Although these standardized elements may be appropriate for inpatient Post-Acute Providers, we continue to have concerns related to their relevance for HHAs, particularly for our beneficiaries served pre-acute or from community-based referrals.** While beneficiaries in SNFs, IRFs and LTACHs have goals that target improvement and inpatient assessments and data points reflect these goals; for the majority of pre-acute beneficiaries served by HHAs, an appropriate goal is to maintain function and not necessarily show improvement. We are not convinced that HHAs should be required to perform and collection these same data points, particularly for pre-acute beneficiaries. This data collection adds unnecessary time, documentation and cost that is not based on individual need but rather regulatory requirements.

We would also like to particularly comment on the collection of social determinants of health (SDOH) data. It is widely accepted that SDOH greatly impact an individual’s health and quality of life. The challenge with requiring healthcare providers to collect additional SDOH data is that we don’t know the most useful social risk data to collect and collecting a very comprehensive record comes with significant administrative burden. **We do support an approach based on current collection tools that transforms select general data categories into more discrete data points that can be aggregated and analyzed for programmatic strategies/policy.** For example, a “Housing” category could have options for “Own Home, Rent Home, Homeless, Other.” While we support the incorporation of SDOH to promote access and assure high-quality care for all beneficiaries, we encourage CMS to be mindful of meaningful collection and the potential for data overload as well as the ability to leverage existing data sources from across care settings. Since SDOH have impacts far beyond the post-acute care (PAC) setting, we caution data collection that cannot be readily gathered, shared or replicated beyond the PAC setting. For healthcare settings that have more established EHRs, the collection of SDOH should be aligned and associated costs for gathering, sharing or replicating considered.

As an HHA within an integrated healthcare system, we would encourage CMS to consider leveraging data points from primary care visits. In terms of collecting these data points, we would offer that an initial capture of a small set of social risk information could be extracted from the EHR as the result of the annual wellness visit or social history within the E/M documentation. Per guidance of the American Academy of Family Physicians², the Past, Family, Social History component of the CPT code for E/M visits creates an opportunity to record these data. Below is a table of social risk factors that may already be contained within the EHR and could serve as a starting point, albeit not currently formatted in discrete data points. Administrative burden can be reduced when we use current data sources and collection tools.

Data Points	When Collected	Notes
Employment	At registration if insurance is on employer plan	
Insurance status	At registration	
Transportation	E/M	“who brought you today?”; “do you have a way to get back home and to pick up the medications I’ve prescribed?”
Nutrition	Required as part of the BMI discussion	Noted on After Visit Summary

² <https://www.aafp.org/practice-management/payment/coding/evaluation-management.html>

Personal Safety / falls prevention	In falls protocol	
Ability to afford medications		Quality indicator in the CG-CAHPS “stewardship of patient resources”
Housing	Triggered if home safety concerns	Addressed as home safety falls
Physical activity	E/M	
Substance abuse	E/M	Includes tobacco
Mental health	Separate depression screening at visits	
Disabilities	HCC and updated problem list	
Family and community support	Updates if care navigator or coordinator	

In theory, the ability to have a hospital’s or physician’s EHR also collect, capture and exchange segments of this information is powerful. This assumes that the underlying assessment was accurate and properly documented and that the information is a value-added item – clinically meaningful and not cost prohibitive. **We urge CMS to take a holistic view of SDOH across the care continuum so that all care settings may gather, collect or leverage this data efficiently and the collection will yield the utmost impact.**

OASIS Reporting Request for Information: *CMS plans to expand the reporting of OASIS data used for the HH QRP to include data on all patients, regardless of their payer, in future rulemaking. CMS is seeking input on: (1) Whether HHAs agree about the need to collect OASIS data regardless of payer?; (2) What percentage of patients are outside OASIS data reporting?; (3) Whether there are specific reporting burdens associated with this proposal?; (4) Any noted differences in patient mix or in outcomes between those patients within current OASIS data and those outside current OASIS data.; and (5) Any other considerations related to expansion of OASIS data reporting.*

Comment: **UnityPoint at Home already collects OASIS information for all patients regardless of payer and would support this reporting expansion.** In fact, this change would reduce our administrative burden as it would eliminate an OASIS question and avoid situations where our HHAs have inadvertently submitted data to OASIS for “other payer” patients. Inadvertent submissions, although infrequent, require patient notification and additional processes to remove these data points.

Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HCAHPS): *Beginning July 1, 2020, CMS is proposing to remove Question 10 from all HCAHPS Surveys (both mail surveys and telephone surveys) which says, “In the last 2 months of care, did you and a home health provider from this agency talk about pain?” This measure is currently one of seven questions in the “Special Care Issues” composite measure.*

Comment: **We support removal of Question 10.**

IV. MEDICARE COVERAGE OF HOME INFUSION THERAPY SERVICES

Home Infusion Therapy Services – Scope of Benefit and Condition for Payment: *CMS is proposing the scope of the home infusion drugs eligible for coverage of home infusion therapy services, outlining beneficiary qualifications and plan of care requirements, and establishing the suppliers and professionals services that may bill for payment under the benefit. CMS is clarifying that in CYs 2019 and 2020, if a beneficiary is homebound and under a Medicare home health plan of care, the HHA*

should continue to furnish the professional services related to the administration of transitional home infusion drugs. In addition, CMS is soliciting comment on the appropriate form, manner, and frequency that any physician must use to provide notification of infusion therapy options available prior to furnishing home infusion therapy services.

Comment: In general, since most home infusion drugs are included under Part D, we believe the scope of this benefit (as evidenced by Table 28) will be very narrow in relation to this extensive new regulatory framework. In terms of the physician notification, we appreciate that CMS is seeking stakeholder input and **recommend a streamlined notice at the beginning of treatment** to avoid any associated service delays. We have concerns that, in many instances, the physician is not the appropriate resource to know what place of service beneficiaries can get their home infusion drugs from, so we would request that CMS permit sufficient time for physicians to research place of service. We would also recommend that CMS develop a single form for this notice to standardize its format and avoid benefit denials, and that only one notice be required at the start of therapy, since many of these therapies have a duration for the life of the beneficiary.

In addition, we request that CMS provide clarification on the following:

Availability of Professional Services: Among the required services, professional services must be available on a 7-day-a-week, 24-hour-a-day basis in order to ensure that patients have access to expert clinical knowledge and advice in the event of an urgent or emergent infusion-related situation. **We would request that CMS further clarify this availability of professional services requirement to include professional services provided “on-call” as well as extending beyond nursing services.**

Infusion Drug Administration Calendar Day: We request that CMS revisit this definition, which triggers when a supplier can bill for home infusion therapy services. **We would suggest adoption of this revised definition: Infusion drug administration calendar day means the day on which home infusion therapy services are furnished in the individual’s home on the day of infusion drug administration.** This eliminates a burdensome and unnecessary requirement that skilled professionals (i.e. nurses) be physically present in an individual’s home on the day the infusion drug is administered for payment to occur. For instance, in many cases, subcutaneous IVIG tier 2 and tier 3 medications are self-administered after training is received from healthcare professionals. Our suggested revised definition recognizes standard industry practice which rely on patients to self-administer these drugs without a physical presence requirement. In addition, the revised definition aligns with the statute’s plain language and Congressional intent and eases demands on workforce shortages, particularly in rural areas.

Home Infusion Drug: Both statute and regulation define this term as “a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment.” The billing commentary states “Each visit reported would include the length of time in which professional services were provided (in 15 minute increments).” **We encourage CMS to further clarify in regulation or guidance how the 15-minute duration for reimbursement purposes is operationalized.** We would request that the clarification include that the 15-minute duration applies to both intravenous and subcutaneous administration, and that administration time should be rounded up in 15-minute intervals. This recommendation will address that administration

reimbursement will not be pro-rated or denied for increments less than 15 minutes and that this timeframe does not solely apply to subcutaneous administration.

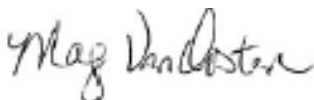
Home Health Benefit Overlap: It has been cumbersome for HHAs to distinguish when to bill under the home health benefit versus the home infusion benefit. On January 1, 2021, the 21st Century Cures Act excludes home infusion therapy from home health services, so a bright line is established. For CYs 2019 and 2020, the rules are not as clear. The Medicare home health benefit is triggered (with associated HHA billing for professional services related to the administration of transitional home infusion drugs), when a patient is homebound and under a Medicare home health plan of care regardless of whether home infusion therapy services are provided by the HHA or contracted home infusion supplier. The HHA is the only entity eligible to bill for these services under the Medicare home health benefit. **We request that CMS further clarify whether there are any circumstances under which an HHA may bill for the home infusion benefit.**

CY2021 Payments and Adjustments: *CMS is establishing three payment categories, with the associated J-code for each transitional home infusion drug. Payment amounts per category, for an infusion drug administration calendar day under the permanent benefit, are proposed in accordance with the six PFS infusion CPT codes and units for such codes. Payment adjustments include the proposed payment equivalent to 5 hours of infusion in a physician's office and increasing the payment amounts for each of the three categories for the first home infusion therapy visit by the average difference between the PFS amounts for E/M existing patient visits and new patient visits for a given year. For CY2021, payments are adjusted by the geographic wage index and the consumer price index. As proposed, CMS has not proposed prior authorization requirements or high-cost outliers but intends to monitor and will address in future rulemaking as needed.*

Comment: CMS has indicated that definition of "home infusion drug" excludes self-administered drugs or biologicals on the self-administered drug (SAD) exclusion list. In the narrative, Hizentra was listed as an example. In Table 28, Category 2 contains Hyqvia, which also appears on the SAD exclusion list. We believe that Hyqvia may have been erroneously included in Table 28.

We appreciate the opportunity to provide comments to the proposed Home Health rules and their impact on our home health agency and beneficiaries. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President, Government & External Affairs at sabra.rosener@unitypoint.org or 515-205-1206.

Sincerely,



Margaret VanOosten, RN, BSN
President & Chief Clinical Officer
UnityPoint at Home



Sabra Rosener, JD
VP, Government & External Affairs
UnityPoint Health